

Minutes of Meeting
Health Services Council
Project Review Committee-I

DATE: 22 January 2008

TIME: 2:30 PM

LOCATION: Conference Room 401
Department of Health

ATTENDANCE:

Committee I: Present: Victoria Almeida, Esq., (Vice Chair), John W. Flynn, Amy Lapierre, Thomas M. Madden, Esq., Robert J. Quigley, DC, (Chair), Larry Ross

Not Present: Joseph V. Cetnofanti, M.D., Robert Ricci, Robert Whiteside

Excused Absences: Edward F. Almon, Robert S.L. Kinder, M.D.

Committee II: Present: Reverend David Shire

Staff: Valentina Adamova, Loreen Angell, Michael K. Dexter, Robert Marshall, PhD., Joseph G. Miller, Esq.

Public: (attached)

1. Call to Order, Approval of Minutes, Conflict of Interest Forms and Time Extension for the Minutes Availability

The meeting was called to order at 2:30 PM. The Chairman noted that conflict of interest forms are available to any member who may have a conflict. The Chairman requested a motion for the extension of time for the availability of minutes pursuant to the Open Meetings Act. A motion was made, seconded and passed by a vote of six in favor and none opposed (6-0) that the availability of the minutes for this meeting be extended beyond the time frame provided for under the Open Meetings Act. Those members voting in favor were: Almeida, Flynn, Lapierre, Madden, Quigley, Ross

2. General Order of Business

The first item on the agenda was the application of Rhode Island Hospital for a Certificate of Need to establish pediatric and adult bone marrow transplantation services.

The Chair noted that at the last meeting Rhode Island Hospital (RIH) and Roger Williams Medical Center (RWMC) were asked by the Committee to work on a collaborative and cooperative approach to bone marrow transplantation (BMT) as there is already a unit at

RWMC. He stated that the Committee feels cooperation and collaboration should be achieved in lieu of setting up new technology and programs at hospitals when capacity exists for collaboration. He cited collaborative approaches by other applicants.

Mr. Belcher, President of Roger Williams Medical Center and Mr. Vecchione, President of Rhode Island Hospital were asked by the Chairman to elaborate before the Committee as to why collaboration was not an option.

Mr. Vecchione stated that the main issue prohibiting collaboration is site location. He indicated that the premise of RWMC response is that collaboration is possible as long as it is related to the unit at RWMC. He stated that RIH would welcome collaboration if the BMT unit was located at RIH. He stated that over $\frac{3}{4}$ of BMT are currently being referred out of state. Mr. Vecchione noted that in discussion with referring physicians he found they refer to programs where they feel patients will get the level of service expected by the physician. From the perspective of RIH an existing need is very clear for both the adult and the pediatric side. Mr. Vecchione referenced the strong physicians and pediatric care at the Hasbro Children's hospital and the emotional and financial hardship endured by families and patients by going out of state. Addressing the issue of affordability, Mr. Vecchione stated that the payers - Blue Cross, United, etc. – were paying the providers in Boston for Rhode Island cases. He indicated that approximately 35 to 55 additional well-paying jobs in the state of

RI would be generated by the creation of a BMT unit at RIH, with more local care being provided for the residents of RI.

The Chair inquired as to any plans for the utilization of RWMC's BMT. He stated that a team could be assembled to work at both institutions, allowing both hospitals to be considered advanced cancer treatment centers. Mr. Vecchione indicated that recent conversations with RWMC have entertained centers in place at both sites and an economic model that might be appropriate was mentioned. Mr. Belcher responded that the initial question of CON was raised due to the fact that a well-established BMT program exists in RI but is underutilized. RWMC has the capacity to handle between 55 and 70 bone marrow cases per year and prior to the transition of some staff from RWMC to RIH, the volume coming through the RWMC program was in the range of 24-30. Mr. Belcher indicated that he was in favor of collaboration while utilizing the existing program to its full capacity. He noted that the state is facing budgetary issues and stated that it would be a disadvantage to invest money for the implementation of an additional program when a program with sufficient capacity exists. He indicated physicians have been welcome to collaborate in RWMC's program by maintaining admitting privileges, sharing in joint research protocols and patient care protocols, for a program that is truly collaborative.

Mr. Flynn asked Mr. Belcher if the three doctors that left were members of the BMT team. Mr. Belcher noted they were not full time

transplantors but were members of the BMT team. Mr. Flynn inquired if referrals were lost due to the departure of those physicians, which Mr. Belcher affirmed. Mr. Flynn indicated that he has not seen evidence demonstrating the need for two programs.

Ms. Lapierre raised a question regarding the cost impact on Medicaid and Rlte Care, as the responses to a DHS letter did not project any Rlte Care patients utilizing this service. The applicant stated that the reason Rlte Care patients were not identified in the cost analysis was due to the fact that there was no instance of a Rlte Care patient going to Boston for services in the database that was used for the analysis. As a result it was not clear what the rate of incidence was, but the applicant indicated that this population would not be excluded from receiving services.

Ms. Lapierre noted that without any patients in that category, the Medicaid program overall would bear an unproportionate share of costs if there was a ratio cost to charges reflecting the underlying cost to implement the program. The applicant noted that the costs would be incurred irrespective of where a Rlte Care patient presented.

Ms. Lapierre inquired if a process similar to an arrangement that exists with Women and Infants, where NICU costs are not part of ratio cost to charges formula could be considered, as opposed to sharing in the underlying cost of this, even if Medicaid or Rlte Care patients are not using the service. This would be a pay per instance agreement. The applicant indicated that the approach did not sound

unreasonable but financial counsel was not present to discuss this issue.

Mr. Normand, legal counsel for RWMC, provided utilization statistics for fiscal years 2005, 2006 and 2007 for the RWMC's unit. He noted that in those years there were 7 Neighborhood Health Plan, 4 United Rlte Care and 35 Medicaid patients. It was requested that this information be provided to the Committee.

Mr. Ross asked Mr. Vecchione and Mr. Belcher regarding the previous mention of recent conversations surrounding the concept of a single program with two transplant sites, one at RIH and one at RWMC. Mr. Vecchione indicated that a recent discussion with RWMC involved a proposal which would not require closure of the RWMC program but would give RWMC a passive investment in the RIH program should the application be approved. Therefore, if the RIH program was financially successful, RWMC would benefit. An alternative arrangement was proposed to the effect of economically combining the two programs and sharing equitably in the economic performance of the combined programs. This proposition was not fully fleshed out.

Mr. Ross inquired if the potential existed to have additional conversations surrounding the mentioned proposal. Mr. Belcher indicated RWMC would consider what was proposed but still believes the current program should be utilized to capacity.

Mr. Flynn noted that this proposal would yield two units, causing a large increase in cost, when a program exists that can handle all the volume. He suggested that the discussions ensue regarding making the program that exists workable and able to attract the volume going out of state. He noted that RIH recruited 3 physicians from RWMC and this is having a negative impact on RWMC as those physicians are sending patients to Boston. If this were reversed some volume would be regained.

The Chair stated that he shares Mr. Flynn's concern and that 25% of patients are diverted by United Healthcare, not affording the opportunity for local treatment. He indicated either one or two facilities need to meet the BMT criteria of United Healthcare, and the Health Insurance Commissioner has recommended collaboration to this end. Staff noted that information was requested from Blue Cross Blue Shield (BCBS) and United regarding standards for care; information has been received only from BCBS.

With regards to concerns about cost increases, Mr. Vecchione noted that 75% of Rhode Island citizens needing BMT care are currently treated out of state with payors paying out of state providers (mostly in Boston) at Boston rates. Mr. Vecchione indicated that the RIH program would create an additional 35 jobs, and up to 55 as it matures, and the amount paid by the payors could conceivably decrease. He argued that the cost to the system in the state of RI

would not be any greater, and the creation of additional jobs in the state would equal a net plus. Additionally, financial and emotional impact on families would be alleviated, as they would not have to travel for an extended period of time to be with their loved one. Mr. Vecchione argued that while the addition of the BMT unit would be a new investment of \$1.7 or \$1.8 million, it would be worth it when the extended benefit of program is considered.

Mr. Flynn noted that with one program in RI the unit cost would be lower, yielding even greater savings. Mr. Vecchione agreed, indicating that he was not proposing RWMC cease and close but volume has not been going to RWMC.

Mr. Belcher responded that the bottom line was fully utilizing an existing RWMC program. He stated that the BMT at RWMC is a program people should feel good about noting it recently received a matched unrelated donor designation from the National Marrow Donor Program (NDMP), enabling patients to participate in the NDMP to receive donors beyond relatives. Mr. Belcher emphasized that that program is being recognized as a good program from a national level and feels a good existing program should be filled up prior to investing in a second. He cited a strong pathology program supporting the service as stem cell and bone marrow work is about working toward those cells that create new blood. With regard to United Healthcare patients receiving care out of state, Mr. Belcher stated that a ceiling number of 60 needs to be achieved to meet

United Healthcare's criteria to be reimbursed. He stated that he felt United Healthcare would agree that RWMC's program is strong. Mr. Belcher noted that 60 was a high ceiling number and raised the question as to what the actual need is in Rhode Island.

The Chair recognized that the provision of a broad range of procedures to include BMT is a requirement for designation as a comprehensive cancer center. He inquired as to whether or not this was a concern of the institutions. He also asked if the parties felt there was potential for collaboration to form a single program at two sites.

Mr. Vecchione indicated that discussion had recently begun for a similar model. He suggested referring physicians be heard from as to why they are referring patients out of state. Mr. Vecchione argued that referrals will not be affected by RIH agreeing to have the BMT unit located at RWMC and that the only thing that would change referral patterns would be two programs functioning in harmony.

The Chair noted that United Healthcare would likely approve of this arrangement if the two programs met both the volume criteria and quality standards. He noted that if discussions between the parties on this subject continue, it would enable this application to go forward. He stressed collaboration and cooperation as being necessary. Mr. Ross recognized the complexity and difficulty of the process but encouraged both parties to continue discussions.

Mr. Belcher recognized that certain physicians will refer to Farber regardless of what type of program is in place in Rhode Island, but was concerned of the implication of a previous comment that physicians refer elsewhere due to the quality of the RWMC program. He pointed out collaboration between the two programs would not guarantee the end of referral to Boston. The Chair and Mr. Vecchione agreed.

Ms. Lapierre noted that in the RIH application it was projected that 100% of pediatric cases would be captured. The applicant noted that most pediatric referrals are generated through Dr. Swartz of RIH. Dr. Swartz noted that RIH currently receives 95% of pediatric oncology cases in the community but recognized this did not mean there might not be a child with a very rare disease that would need to be referred out of state. She noted that conversely, certain expertise in unusual tumors at RIH would bring out of state children to RIH for treatment.

Ms. Lapierre countered an assumption put forth by RIH in the application that no traffic would be taken from RWMC and traffic generated at RIH would be new. She pointed out that RIH has yet to establish a BMT and RWMC has already seen a downward trend in numbers.

To Mr. Madden's question about hardship faced by patients, Mr. Belcher stated that RWMC has been very concerned about the

hardship incurred by patients going to Boston. He noted that with the transition of physicians to RIH, patients who were already in the system ended up going elsewhere. He referenced a case in which a family was denied services at Farber due to lack of reimbursement because the patient was a Rhode Island resident. He indicated the family was referred to RWMC by an independent agency and RWMC treated that case. Mr. Belcher noted that he wondered how many patients automatically go to Boston that could stay in the system. He recognized there is much collaboration that could be achieved from a pediatrics standpoint while the stem cell component would reside at RWMC. Mr. Belcher asked Dr. Abby Maizel, pathologist of RWMC, to expound on his experience in the referral process with respect to specimens.

Dr. Maizel stated that the RWMC center sees a majority of the bone marrow samples involved in making a primary diagnosis. He noted that one of the confusing issues in pathology is the referral outside local networks. He also indicated that most of the hematopathology is in the region RWMC services and the numbers that come through do not support the possibility of two units functioning separately. Dr. Maizel noted that the problem exists of cases being referred to the Boston community and discussion has taken place regarding the 60-70% case loss. He noted most of those referrals are coming from the physicians in the institution proposing the new unit so it is a self-fulfilling prophecy. If 10 individuals working out of Rhode Island refer to Boston, those patients cannot be recaptured until those

physicians cease referring out of local network. Dr. Maizel argued until this pattern ceases the need for a second unit cannot be evaluated.

Mr. Vecchione responded to the earlier question of Mr. Madden regarding families for which going to Boston is a hardship. He stated that RIH has heard from physicians that the lack of 24-7-52 tertiary service coverage is the issue and as this limitation has not been addressed to the physicians' satisfaction they refer outside of the local network. Mr. Vecchione indicated that the application went forward with the physicians' encouragement.

Dr. Klein, of RIH, noted that due to his involvement three BMT programs over the years he has had much experience trying to model such programs. He noted that patients are connected to a BMT center via referral and not personal decision. He indicated that the state employs a highly trained, competent group of hematologists/oncologists at many hospitals and this group of physicians largely received their training in broad range academic medical centers. Therefore, he argued that by virtue of their training they tend to refer to like institutions. Dr. Klein indicated that RIH hoped to establish a RIH/Brown program which would be an academic and tertiary center.

Dr. Weitberg, Chairman of Medicine at RWMC, noted that he is a hematologist/oncologist, has been a physician in the state for over 30

years and knows the hematology/oncology doctors of the state well. He indicated that BMT centers at institutions the size of RWMC occur throughout the country and are utilized when they are high quality. Dr. Weitberg argued that the RWMC program is high quality and a political component exists that cannot be overlooked. He cited an example of a Medicare case referred to Dana Farber by a physician at RIH. The patient was asked at Dana Farber why she was there as there was an excellent program in RI. The patient was sent back to RWMC for evaluation and the patient's physician called Dana Farber to say he/she did not want the patient to be seen at RWMC. Dr. Weitberg indicated he felt if RI physicians were queried it would be discovered that many are pleased with services provided at RWMC. He noted that the program has gotten back on track after the loss of physicians, with a new transplant director on board and physicians around the state referring to RWMC again. He noted that the only physicians not referring to RWMC are those based at RIH and argued that this situation was not due to quality. Dr. Weitberg also stated the assumption that only a large center can have a BMT unit is not valid.

Dr. Espat, Chief of Surgical Oncology at RWMC, referenced a previous comment regarding 24-7 coverage for surgical and medical sub-specialties stating he would challenge any question regarding the concern of 24-7-52 coverage at RWMC. He stated that as a testament of the high level of surgical/oncologic care at RWMC is the existence of 1 out of 18 society surgical oncology approved programs for fellowship training for future surgical oncologists at RWMC.

Mr. Vecchione inquired if the Committee would welcome hearing directly from a parent who was in need of service who had to go out of state. The mother of the patient who had to go out of state to receive BMT services for her son shared her experience regarding the financial and emotional hardship of having to travel out of state while her son was receiving services. She noted that RWMC has a program in place but preferred treatment at a pediatric hospital for her son.

The Chairman indicated the Committee has expressed their thoughts and expectations and requested the parties return to recent conversations surrounding collaboration. The next meeting was scheduled for 19 February 2008.

There being no further business the meeting adjourned at 3:47 PM.

Respectfully submitted,

Loreen Angell